THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM:
PRELIMINARY HIGHLIGHTS OF IMPLEMENTATION AND EXPANSION

President Clinton, with overwhelming bipartisan support from the Congress, created the State Children's Health Insurance Program (S-CHIP) in 1997, allocating $48 billion over the next 10 years to expand health care coverage to uninsured children. This new program, together with Medicaid, provides meaningful health care coverage to millions of previously uninsured children – including coverage for prescription drugs, vision, hearing, and mental health services. Today, every state has implemented S-CHIP, providing health insurance coverage to over 2 million children nationwide since the beginning of the program. The success of this Federal-State partnership is one of the most significant achievements of the Clinton-Gore Administration. This summary includes highlights from state-submitted evaluations of their S-CHIP programs.

BACKGROUND

The State Children's Health Insurance Program (S-CHIP) enables states to insure children from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance through separate state programs, Medicaid expansions, or a combination of both. Each state with an approved plan receives enhanced Federal matching payments for its S-CHIP expenditures up to a fixed state "allotment". As of July 1, 2000, 50 States, the District of Columbia and five U.S. Territories have implemented S-CHIP, covering over 2 million children. In addition, the number of children enrolled in Medicaid has increased because of state-wide outreach and eligibility simplification efforts.

Of these approved plans, 15 States have created a separate child health program, 23 States have expanded Medicaid, and 18 States have developed a combination of a separate state program and a Medicaid expansion program. In addition, many states have already amended their programs to expand eligibility beyond their original proposal. Prior to S-CHIP's creation, only 4 states covered children with family incomes up to at least 200 percent of the Federal poverty level (about $33,000 for a family of 4). Today, 30 states have plans approved to cover children with incomes up to at least this level.

However, millions of eligible children remain uninsured. One study found that two-thirds of eligible uninsured children are in two-parent families. Over seventy-five percent of the parents of these children work, and only 5 percent receive welfare. Nearly all low-income parents believe having health insurance coverage for their child is very important, and two-thirds of them have tried to enroll their children in Medicaid. However, over 57 percent of these attempts were unsuccessful. Studies indicate that lack of coverage negatively affects access to care among low-income children – 41 percent of parents of eligible uninsured children postponed seeking medical care for their child because they could not afford it.

States have made strong progress in implementing their S-CHIP programs, seeking and implementing new and innovative ways to identify and enroll uninsured children in both Medicaid and S-CHIP. The steady growth of the S-CHIP program is evidence of the success of this Federal-State partnership and the nation's commitment to ensuring that all children have health insurance coverage.

STATE EVALUATIONS

The S-CHIP statute requires States to regularly report on their progress toward covering low-income children under S-CHIP, and required that each State or Territory with an approved child health plan must submit to the Secretary of Health and Human Services an evaluation of its S-CHIP Program by March 31, 2000. These evaluations provide States with an opportunity to document program achievements, assess the effectiveness of their programs, and identify ways in which the State or the Federal government might improve program performance.

Working with the states, the Department of Health and Human Services (HHS), and other interested parties, the National Academy of State Health Policy facilitated the evaluation process and created an "evaluation framework" for the States that enabled them to report their findings in a standardized manner. The states' evaluations provided HHS with valuable information on best practices as well as challenges facing states in the implementation of their programs. This information, which is available to the public, will be used to provide continuing technical assistance to facilitate future program innovations. The States' evaluations will be posted on the HCFA web site at www.hcfa.gov.

The forty-seven state evaluations submitted as of July 1, 2000 offer important insights into the experiences and future direction of S-CHIP. The information that follows is a short description of preliminary findings from the States' reports, quarterly enrollment data currently available, and regional office reviews of Medicaid enrollment and eligibility processes.

STRONG ENROLLMENT TRENDS CONTINUE

Nearly 2 million children were covered by S-CHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998, and initial reports indicate that these strong enrollment trends are continuing through the first quarter of 2000 (although data from all states is has not yet been submitted). For example, from the second quarter of fiscal year 1999 (April 1 – June 30, 1999) to the second quarter of 2000 (April 1 – June 30, 2000), enrollment increased by more than 80 percent in the 43 states for which there are data. During that time period, 19 states reported that their enrollment had more than doubled, and nine of those states reported that their program enrollment had tripled.

ELIMINATING BARRIERS TO INITIAL AND CONTINUED ENROLLMENT

States reported having worked aggressively to simplify their application, enrollment, and re-enrollment processes to ensure that eligible families can easily apply, enroll, and remain enrolled. Steps such as using a joint and mail-in applications, offering presumptive eligibility, allowing retroactive eligibility, and providing continuous eligibility are all important strategies for simplifying the enrollment process and providing opportunities for families to apply and remain enrolled in Medicaid and S-CHIP.

Coordinating Enrollment and Eligibility Requirements for Medicaid and S-CHIP

In order to ensure that children receive the most generous benefit package for which they are eligible, 29 states – over 85 percent of those with separate state programs or combination programs – report using a joint application to enroll families in their Medicaid or separate child health program. These states confirmed that using one application for both Medicaid and their separate child health program reduces paperwork, minimizes processing errors, and offers a less intrusive, more family-friendly approach to the application process.

In addition, 39 states have eliminated face-to-face interviews in Medicaid for children or in both Medicaid and the State's separate S-CHIP program.

In addition, only seven states currently require an assets test for children enrolling in Medicaid or the S-CHIP program. Out of the 17 states with combination programs, 16 have dropped the assets test in both their Medicaid expansion and their separate state program, while one has dropped it for the S-CHIP program but not Medicaid. Thirteen of the 17 states with Medicaid expansions have dropped their assets test. Over the past several years, states have dropped this requirement in the face of mounting evidence and state experience that it serves as a barrier to enrollment.

North Carolina's Health Choice For Children Program. North Carolina has successfully implemented strategies to simplify the application and enrollment procedures for families for both Medicaid and S-CHIP. The state:

- Uses a joint application for Medicaid and S-CHIP;
- Guarantees eligibility for 12 months in S-CHIP and Medicaid;
- Provides a simplified two-page application in English and Spanish;
- Allows mail-in applications;
- Cross-trained eligibility workers so they would have the expertise to determine Medicaid or S-CHIP eligibility from the application in one review, shortening the time involved in processing applications and minimizing potential errors; and
- Automatically notifies families when it is time for them to re-enroll their children in Medicaid or S-CHIP.

Ohio's Healthy Start. Ohio recently eliminated burdensome eligibility verification requirements, such as proof of residency and birth date, for children applying for Medicaid (which includes their S-CHIP Medicaid expansion). In addition, the state:

- Uses a two page simplified application;
- Allows applications to be mailed-in; and
- Eliminated requirement for a face-to-face interview before determining eligibility.

As of July 1, 2000, Ohio also expanded coverage for parents through Medicaid up to 100 percent of the poverty level.

Oklahoma's SoonerCare. Oklahoma, which has also implemented important simplification measures in its Medicaid expansion program, has been consistently successful in its outreach and enrollment efforts. The state has:

- Simplified their application from 16 pages to 1 page;
- Over 40 outstationed eligibility workers that travel the state and conduct on-site enrollment at community based sites; and
- Eliminated the assets tests and accepts self-declaration of income.

Providing Children With Immediate Access to Health Care Services

The Balanced Budget Act of 1997 provided states with new authority to make children "presumptively eligible" for Medicaid in order to provide them with immediate access to health care services. This new authority allows designated providers/individuals to enroll children in the programs on a temporary basis, relying on information supplied by the family, until the final eligibility determination is made by the appropriate State agency. Ten states have taken advantage of this new authority in either Medicaid or S-CHIP. In the states with separate programs, five states have taken advantage of this new authority in both programs, despite evidence that this option allows children to receive health care services promptly, ensures providers are paid for services delivered, and enhances opportunities for families to apply for coverage in community based settings.

Nebraska's Kids Connection. Nebraska allows providers eligible to receive Medicaid payments and agencies authorized to determine eligibility for programs such as Head Start, child care services, or WIC to determine presumptive eligibility for Medicaid. Nebraska has found that presumptive eligibility provides an opportunity for continuity of care and implementation of treatment upon evaluation by the provider.

Providing Consistent Access to Health Care Services

The Balanced Budget Act of 1997 gave states the option to enroll children in S-CHIP and Medicaid for up to 12 months, regardless of changes in income or family circumstances. Thirty-two states –over 60 percent – have taken advantage of this new authority to ensure that children enrolled in S-CHIP do not lose their coverage unnecessarily as a result of temporary changes in income or fluctuation in monthly paychecks. All but four States have taken advantage of this new option in Medicaid as well as S-CHIP. These states provide continuous eligibility for either 6 or 12 months after a child has been determined eligible for S-CHIP, even if there is a change in the family's income, assets, or size.

Maine's CubCare. Families have a simple renewal process in which the family is sent a letter containing their income information and is asked simply to respond to the letter to continue their eligibility for the program.

- Single application for CubCare and Medicaid;
- Mail-in applications; and
- Eliminated the assets test.

Redetermination processes also affect continuity of care, since unnecessary disenrollment disrupts

access to care, and hinders state efforts to increase enrollment. States reported that disenrollment rates from separate child health programs were, on average, lower than Medicaid expansion disenrollment rates; and attributed this to the more stringent requirements in Medicaid that require families to report changes in age or income. It is important to note that income and other eligibility reporting requirements are state options and not mandatory.

This information can yield important insights for States regarding processes that may need to be simplified or barriers to enrollment or retention that merit further examination.

Ensuring that Families Moving From Welfare to Work Retain their Health Insurance

Welfare reform created a unique challenge to ensuring that eligible families enroll in Medicaid and now S-CHIP. Prior to reform, Medicaid eligibility was linked to welfare. The President insisted in signing the welfare reform law that all families who would have been eligible for Medicaid prior to the law remain eligible. However, HCFA received a number of reports indicating that states had not made the necessary adjustments to state and/or local policies, systems and procedures in order to ensure that individuals in families transitioning to work were enrolled Medicaid and S-CHIP when eligible. To address this issue, last August, HCFA initiated comprehensive, on-site reviews of state Medicaid enrollment and eligibility processes. These reviews included interviews with state officials and case file checks to assess compliance with current law and to develop recommendations for improvements. After completion of the reviews in all 50 states, we are aware of serious problems in a number of states.

In some situations, state policies have been out of compliance with Federal regulations. For example, in some states, families and children are disenrolled from Medicaid without the state reviewing whether the parent or child continues to be eligible under another eligibility category.
More frequently, State practices and procedures, often due to delays in reprogramming computer systems to account for the delinking of cash assistance and Medicaid, have led to problems. For example, in some states, when cash assistance ended, Medicaid was automatically terminated even though in almost all cases the children and the parent would have been eligible for continued coverage.

While states have made great strides in reducing the barriers to enrollment for children, many of these same barriers continue to operate to keep low-income families from receiving the Medicaid coverage they need as they move from welfare to the workplace. These barriers undermine State welfare reform goals and limit our ability reach our enrollment targets for children. For example, most states still retain a face to face interview requirement for low-income families needing Medicaid, and do not allow families to apply or to retain eligibility through a mail-in systems.

However, despite these problems, a number of states have taken strong action to ensure that families are not unnecessarily or erroneously terminated from health insurance coverage. They include:

Delaware. The state of Delaware has developed a computerized eligibility system that automatically evaluates an individual's eligibility across programs, ensuring that families retain their eligibility for Medicaid and food assistance as they move in and out of the welfare systems. The system evaluates the eligibility of everyone in the family, because even if a parent is determined to be ineligible, the children in the family could still retain their eligibility.

Washington. Upon identifying that the state's computerized eligibility and enrollment system was automatically disenrolling individuals leaving welfare who were still eligible for Medicaid, the state has attempted to reinstate close to 100,000 individuals to coverage. In addition, the state streamlined its Medicaid eligibility reviews by relying on available information in Food Stamp files to recertify Medicaid eligibility. This eliminates unnecessary requests for information from low-income working families and reduces burdens for State and local Medicaid agencies

IMPLEMENTING INNOVATIVE OUTREACH STRATEGIES

The success of S-CHIP programs nationwide is dependant on aggressive, broad-based outreach efforts to identify and enroll eligible children. Low-income working families who have never been eligible for traditional public assistance programs – but who are now eligible for S-CHIP and Medicaid – may not realize that they can receive benefits. In some states, the application process can be long, arduous, and beyond the ability of many families to complete. Cultural barriers, like difficulties in language comprehension, also pose a barrier for some families. States have taken strong action to reach out to families to educate them about this new program and encourage them to apply.

School-based Outreach Strategies

Because schools are accepted by parents as a conduit for important information, school systems are an ideal place to identify and enroll uninsured children in Medicaid or CHIP. In addition, health insurance promotes access to needed health care, which experts confirm contributes to academic success. Children without health insurance suffer more from asthma, ear infections, vision problems - treatable conditions that dramatically interfere with classroom participation. And children without health insurance are absent more frequently than their peers. States with particularly innovative and aggressive school-based outreach strategies include:

New Jersey's KidCare. At the beginning of the school year, Governor Whitman sent a letter to school principals about KidCare and provided each school with 500 brochures on S-CHIP and Medicaid to distribute to parents. Schools, together with local parent-teacher organizations, are also using report card days and direct mailings as opportunities to share information about S-CHIP. Parents completing the application for the Free and Reduced Cost Lunch program can request to receive information about NJ KidCare. School nurses and child study team members have been trained to assist families in completing applications. As a result, New Jersey has signed over 19,000 children to Kid Care, the state's S-CHIP and Medicaid program through strong school-based strategies.

Illinois KidCare. Applications for the free and reduced price lunch program in Illinois have a check-off box on the application form for parents interested in receiving further information about KidCare. The Chicago Public Schools distributed information on KidCare as part of their Report Card Pick-up Days in November 1998 and April 1999 at over 600 public schools. KidCare staff have presentations statewide to school administrators, principals, nurses, social workers, and teachers interested in learning more about KidCare to get eligible students enrolled.

Community-Based Efforts

Many states collaborate with community based organizations to ensure that outreach and enrollment strategies are precisely targeted to the needs of local communities. States with particularly innovative and aggressive community-based outreach strategies include:

Indiana's Hoosier Healthwise. In an attempt to reduce the stigma associated with local welfare offices, a key barrier to Medicaid enrollment, the State successfully identified 500 independent enrollment centers throughout Indiana. These enrollment centers include community action centers, child care centers, health centers and hospitals, schools, and various service providers. They have processed over 20,000 applications through the enrollment centers.

Targeted Populations

Outreach efforts geared towards the mainstream population may not be effective for many children eligible for Medicaid and S-CHIP. Vulnerable populations often face socioeconomic or linguistic issues, low literacy levels, geographic isolation, or other barriers that make it difficult for them to enroll in health insurance. States with particularly innovative and aggressive community-based outreach strategies include:

Arizona's KidsCare has launched a concerted effort to reach children in Hispanic families. Activities include:

- Developing Spanish-language applications;
- Creating mass media messages that appealed to the Hispanic population;
- Airing announcements about the program on Spanish language radio and television stations;
- Producing special editions of the Arizona Farmworkers Coalition on KidsCare; and
- Placing the KidsCare logo on the side of traditionally Hispanic businesses, such as "Paletas," ice cream pushcarts used during the summer.

Georgia's PeachCare. Georgia has implemented a concerted effort to reach children in rural areas. The state has:

- Sponsored public service announcements by well-known community members, participated in local parades, and made presentations at local churches;
- Working with local businesses to provide table mats in restaurants, print flyers on grocery bags, and insert "stuffers" in local phone bills; and
- Distributing information on PeachCare to fast food restaurants and small businesses to pass on to their employees.

Table 1 -- State Children's Health Insurance Program (SCHIP)
--- Streamlined Eligibility Processes ---

STATE	Type of SCHIP Program	Upper Eligibility ^^	Combined Application (only SSP)	Continuous Eligibility	Presumptive Eligibility	Dropped Assets Test
Alabama Alabama SSP	Combo	200%	Yes	12 months 12 months	Yes No	Yes
Alaska	Medicaid	200%	N/A	6 months	No	Yes
American Samoa	Medicaid	N/A	NO	REPORT	AVAILABLE	
Arizona	Separate	200%	Yes	12 months	No	Yes *
Arkansas	Medicaid	100%	N/A	No 1)	No	No *
California California SSP	Combo	250%	Yes	No 12 months	No	Yes
Colorado	Separate	185%	Yes	12 months	No	Yes *
CNMI	Medicaid	N/A	NO	REPORT	AVAILABLE	
Connecticut Connecticut SSP	Combo	300%	Yes	12 months 12 months	No	Yes *
Delaware	Separate	200%	Yes	12 months 2)	No	Yes
District of Colombia	Medicaid	200%	N/A	No 1)	No	Yes *
Florida Florida SSP	Combo	200%	Yes	6 months 3) 6 months	No	Yes
Georgia	Separate	200%	Yes	No 1)	No	Yes*
Guam	Medicaid	N/A	NO	REPORT	AVAILABLE	
Hawaii	Medicaid	185%	NO REPORT	AVAILABLE	(Implemented	July 1, 2000)
Idaho	Medicaid	150%	N/A	12 months	No	No
Illinois Illinois SSP	Combo	133%	Yes	12 months 12 months	No	No
Indiana Indiana SSP	Combo	200%	Yes	12 months N/I	No	Yes
Iowa Iowa SSP	Combo	185%	Yes	12 months 12 months	No	Yes
Kansas	Separate	200%	Yes	12 months	No	Yes
Kentucky Kentucky SSP	Combo	200%	Yes	No 4)	Yes #	Yes
Louisiana	Medicaid	150%	N/A	12 months	No	Yes
Maine Maine SSP	Combo	185%	Yes	6 months 6 months	No	Yes
Maryland	Medicaid	200%	N/A	6 months	No	Yes *
Massachusetts Massachusetts SSP	Combo	200%	Yes	No 1)	Yes Yes	Yes
Michigan Michigan SSP	Combo	200%	Yes	No 1) 12 months	No Yes	Yes
Minnesota	Medicaid	280%	N/A	No 1)	No	Yes
Mississippi Mississippi	Combo	200%	Yes	12 months 12 months	No	Yes *
Missouri	Medicaid	300%	N/A	No 1)	No	No *

STATE	Type of SCHIP Program	Upper Eligibility ^^	Combined Application (only SSP)	Continuous Eligibility	Presumptive Eligibility	Dropped Assets Test
Montana	Separate	150%	No	No 1)	No	Yes (SSP only)
Nebraska	Medicaid	185%	N/A	12 months	Yes	Yes
Nevada	Separate	200%	NO	REPORT	AVAILABLE	
New Hampshire New Hampshire SSP	Combo	300%	Yes	6 months 5) 6 months	Yes No	Yes *
New Jersey New Jersey SSP	Combo	350%	Yes	No	Yes Yes	Yes *
New Mexico	Medicaid	235%	N/A	12 months	Yes	Yes *
New York New York SSP	Combo	192%	Yes	12 months No	Yes Yes	Yes *
North Carolina	Separate	200%	Yes	12 months	No	Yes
North Dakota	Medicaid	140%	N/A	No	No	No
Ohio	Medicaid	150%	N/A	No 6)	No	Yes
Oklahoma	Medicaid	185%	NO	REPORT	AVAILABLE	
Oregon	Separate	170%	Yes	6 months	No	No *
Pennsylvania	Separate	200%	Yes	12 months	No	Yes
Puerto Rico	Medicaid	200%	NO	REPORT	AVAILABLE	
Rhode Island	Medicaid	300%	N/A	6 months	No	Yes *
South Carolina	Medicaid	150%	N/A	12 months	No	Yes
South Dakota	Medicaid	140%	N/A	No 1)	No	Yes
Tennessee	Medicaid	100%	N/A	12 months	No	Yes
Texas Texas SSP	Combo	200%	Yes	No N/I	No	Yes (SSP only) *
Utah	Separate	200%	No	12 months	No	Yes (SSP only)
Vermont	Separate	300%	Yes	6 months	No	Yes
Virgin Islands	Medicaid	N/A	NO	REPORT	AVAILABLE	
Virginia	Separate	185%	Yes	No 1)	No	Yes
Washington	Separate	250%	Yes	12 months	No	Yes
West Virginia West Virginia SSP	Combo	150%	Yes	No 12 months	No	Yes *
Wisconsin	Medicaid	185%	N/A	No 1)	No	Yes
Wyoming	Separate	133%	Yes	12 months	No	Yes

Table 1 – Notes

(Note: The information in this table reflects unedited, unverified information as submitted by the States to HCFA in their March 31, 2000 SCHIP evaluations)

^^ Reflects upper eligibility level of SCHIP plans and amendments approved as of January 1, 2000. Upper eligibility is defined as a percent of the Federal Poverty Level (FPL). In 1999, FPL was $16,700 for a family of 4. In general, States with Medicaid expansion SCHIP programs must establish their upper eligibility levels net of income disregards. States with separate SCHIP programs may establish their upper eligibility levels on a gross income basis or net of income disregards. Puerto Rico defines the upper eligibility limit as 200 percent of Puerto Rico?s poverty level.

N/A Not Applicable

N/I Not Yet Implemented

1\ The State uses a 12 month eligibility redetermination process, but eligibility is not guaranteed if income or other circumstances change.

2\ Delaware has a 12 month eligibility period, assuming premiums are paid.

3\ Florida has a 6 month eligibility period, however children under age five who qualify for Medicaid are eligible for 12 months.

4\ Kentucky?s managed care partnerships provides a 6 month eligibility period, however families must report changes in income and the child?s eligibility may be redetermined prior to the end of the 6 month period.

5\ Eligibility in New Hampshire is guaranteed for six months for infants enrolled in the voluntary managed care program.

6\ Ohio has either a 3 or 6 month eligibility period, depending on whether the child is also enrolled in food stamps. If the child is enrolled in both programs, eligibility is redetermined at 3 months.

Kentucky has presumptive eligibility as part of the approved State plan. The State is currently evaluating whether or not to implement it.

* Information on assets tests was supplemented by a report from the Center on Budget and Policy Priorities/Kaiser Commission on Medicaid and the Uninsured, ?Medicaid for Children and CHIP -- Income Eligibility Guidelines and Enrollment Procedures: Findings from a 50-State Survey?. April 2000.